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2019 JAN 7 PM 2 42

U.S. BANKRUPTCY COURT  
MARY A. SCHOTT, CLERKASSET RECOVERY TRUSTP.O. Box 4296Costa Mesa, CA 92628714-546-8100amelone@asset-recovery.net

## UNITED STATES BANKRUPTCY COURT

## DISTRICT OF NEVADA

\*\*\*\*\*

In re:

USA COMMERCIAL MORTGAGE COMPANY

Debtor(s).

Bankruptcy No.: 06-10725 GWZ  
Chapter 11AFFIDAVIT FOR REIMBURSEMENT  
OF UNCLAIMED FUNDSSTATE OF: CALIFORNIACOUNTY OF: ORANGESOCIAL SECURITY NO/TAX ID: 87-0707497BINFORD MEDICAL  
DEVELOPERS, LLC of 3250 N. Post Rd. #160, Indianapolis,  
(NAME OF CREDITOR/DEBTOR) (ADDRESS) IN 46226317-979-1700 being duly sworn, deposes and says:  
(PHONE NUMBER)

That he/she is a creditor of the above-named bankrupt/debtor or is the debtor. That

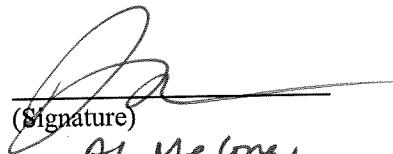
USA COMMERCIAL MORTGAGE COMPANY (Name of Debtor/Bankrupt) was duly adjudged a debtor/bankrupt in the United StatesBankruptcy Court for the District of Nevada. That said creditor duly filed his/her claim, which claim  
was thereafter duly allowed or is the debtor in the above named case.Dividends amounting to the sum of \$ 12,746.52 remain unpaid.That the said claim has not been sold or assigned, and that it is still the property of the  
deponent.It is therefore requested that the Clerk of this Court pay to BINFORD MEDICAL the  
DEVELOPERS, LLC  
sum of \$ 12,746.52.

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Sworn and subscribed to before  
me this \_\_\_ day of \_\_\_\_\_

\_\_\_\_\_  
(Notary Public)

*See attached*

  
(Signature)  
Al McLane,  
ASSET RECOVERY TRUST

## ACKNOWLEDGMENT

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California  
County of Orange )

On 4th January, 2019 before me, Margaret A Sevadjan, Notary Public  
(insert name and title of the officer)

personally appeared AL Melone,  
who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are  
subscribed to the within instrument and acknowledged to me that he/she/they executed the same in  
his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the  
person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing  
paragraph is true and correct.

WITNESS my hand and official seal.

Signature  (Seal)



ASSET RECOVERY TRUST

P.O. Box 4296

Costa Mesa, CA 92628

714-546-8100

amelone@asset-recovery.net

UNITED STATES BANKRUPTCY COURT  
DISTRICT OF NEVADA

\* \* \* \* \*

In re:  
USA COMMERCIAL MORTGAGE COMPANY

Bankruptcy No.: 06-10725 GWZ  
Chapter 11

Debtor(s).

AFFIDAVIT OF SERVICE

Notice is hereby given to the court that on 1/4/19, the U.S.  
Attorney for the District of Nevada was advised, via United States Mail, of the "Motion for  
Payment of Unclaimed Funds."

Date: 1/4/19

Respectfully submitted,



EXHIBIT 1

# **LIMITED POWER OF ATTORNEY/ DECLARATION**

I do hereby grant to **ASSET RECOVERY TRUST**, my sole true and lawful attorney-in-fact for me and in my name, place and stead, giving unto my attorney-in-fact full power to do and perform, on an exclusive basis, all and every act not constituting the practice of law that I may legally do through an attorney-in-fact, for the following limited purpose and for no other:

To reclaim, recover, and return unclaimed funds in the amount of **\$12,746.52** only, less agreed upon fee, to the signatory below.

I do hereby grant my attorney-in-fact every power necessary to carry out the limited purposes for which this limited power of attorney is granted, on an exclusive basis.

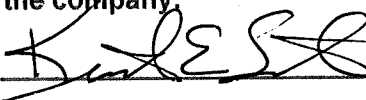
This Limited Power of Attorney revokes all previous powers of attorney granted for the purpose of obtaining dividends from this specific bankruptcy case.

I do hereby declare that **BINFORD MEDICAL DEVELOPERS, LLC** is a rightful creditor of case **06-10725 GWZ, USA COMMERCIAL MORTGAGE COMPANY**, that the enclosed Proof of Claim is a true and correct copy of the original, that we are no longer located at 5200 E. 64<sup>th</sup> St., Indianapolis, IN 46220, that our current address is 3250 N. Post Rd., Suite 160, Indianapolis, IN 46226, that our phone number is 317-979-1700, and that we are entitled to this unclaimed dividend.

I do hereby certify under penalty of perjury under U.S. law that the foregoing is true and correct, and that I have authority to sign for the company.

DATED 12.28.18

SIGNED



NAME Kenneth E. Schmidt

TITLE Managing Member

COMPANY BINFORD MEDICAL DEVELOPERS, LLC

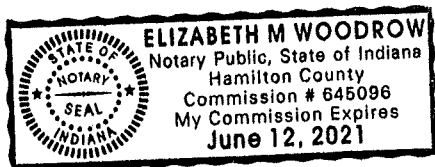
SUBSCRIBED AND SWORN TO BEFORE ME THIS 28 DAY OF DECEMBER, 2018,  
TO CERTIFY WITNESS MY HAND AND OFFICIAL SEAL.

  
NOTARY PUBLIC IN AND FOR

[SEAL]

The State of INDIANA

My Commission expires on JUNE 12, 2021





<b>UNITED STATES BANKRUPTCY COURT</b> <b>DISTRICT OF NEVADA</b>		<b>PROOF OF CLAIM</b>			
Name of Debtor: <b>USA Commercial Mortgage Company</b>		Case Number: <b>05-10725-LBR</b>		<b>E-Filed On 11/9/06</b>	
Name of Creditor and Address: <b>11321280009794</b> <b>BINFORD MEDICAL DEVELOPERS, LLC</b> <b>5200 E 64TH ST</b> <b>INDIANAPOLIS, IN 46226-4708</b>		<input type="checkbox"/> Check box if you are aware that anyone else has filed a proof of claim relating to your claim. Attach copy of statement giving particulars.  <input type="checkbox"/> Check box if you have never received any notices from the bankruptcy court or BNC Group in this case.  <input type="checkbox"/> Check box if this address differs from the address on the envelope sent to you by the court.		<b>DO NOT FILE THIS PROOF OF CLAIM FOR A SECURED INTEREST IN A BORROWER THAT IS NOT ONE OF THE DEBTORS.</b>  If you have already filed a proof of claim with the Bankruptcy Court or BNC, you do not need to file again.  <b>THIS SPACE IS FOR COURT USE ONLY</b>	
Creditor Telephone Number ( ): _____ Last four digits of account or other number by which creditor identifies debtor: <b>Binford Medical Developers LLC</b>		<input type="checkbox"/> Check here if this claim replaces or amends a previously filed claim listed: _____			
<b>1. BASIS FOR CLAIM</b> <input type="checkbox"/> Goods sold <input type="checkbox"/> Personal injury/wrongful death <input type="checkbox"/> (Retiree benefits as defined in 11 U.S.C. § 1114(a)) <input type="checkbox"/> Unreimbursed principal <input type="checkbox"/> Services performed <input type="checkbox"/> Taxes <input type="checkbox"/> Wages, salaries, and compensation (fill out below) <input type="checkbox"/> Other claims against service (not for loan balances) <input type="checkbox"/> Money loaned <input checked="" type="checkbox"/> Other (describe briefly): <b>Breach of Contract</b> Unpaid compensation for services performed from: _____ to: _____ (date) (date)					
<b>2. DATE DEBT WAS INCURRED:</b> <b>June 2006</b> <b>3. IF COURT JUDGMENT, DATE OBTAINED:</b> _____ <b>4. CLASSIFICATION OF CLAIM.</b> Check the appropriate box or boxes that best describe your claim and state the amount of the claim at the time case filed. (See reverse side for important explanations.) <b>UNSECURED NONPRIORITY CLAIM \$3,502,383.00</b> <input checked="" type="checkbox"/> Check this box if: (a) there is no collateral or lien securing your claim, or (b) your claim equals the value of the property securing it, or if (c) none or only part of your claim is tied to priority. <b>5. SECURED PRIORITY CLAIM</b> <input type="checkbox"/> Check this box if you have an unsecured claim, all or part of which is entitled to priority. Amount entitled to priority: \$ _____ Specify the priority of the claim: <input type="checkbox"/> Domestic support obligations under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B) <input type="checkbox"/> Wages, salaries, or compensation (up to \$10,000*), earned within 180 days before filing of the bankruptcy petition or cessation of the debtor's business, whichever is earlier - 11 U.S.C. § 507(a)(4) <input type="checkbox"/> Contributions to an employee benefit plan - 11 U.S.C. § 507(a)(5) <input type="checkbox"/> Up to \$2,250* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use - 11 U.S.C. § 507(b)(7) <input type="checkbox"/> Taxes or penalties owed to governmental units - 11 U.S.C. § 507(a)(9) <input type="checkbox"/> Other - Specify applicable paragraph of 11 U.S.C. § 507(a) ( _____ ) * Amounts are subject to adjustment on 4/1/07 and every 3 years thereafter with respect to cases commenced on or after the date of adjustment.					
<b>6. TOTAL AMOUNT OF CLAIM AT TIME CASE FILED:</b> \$ <b>3,502,383.00</b> \$ _____    \$ <b>3,502,383.00</b> (unsecured)    (secured)    (priority)    (total) <input type="checkbox"/> Check this box if claim includes interest or other charges in addition to the principal amount of the claim. Attach itemized statement of all interest or additional charges.					
<b>7. CREDITS:</b> The amount of all payments on the claim has been credited and deducted for the purpose of making this proof of claim. <b>8. SUPPORTING DOCUMENTS:</b> Attach copies of supporting documents, such as promissory notes, purchase orders, invoices, itemized statements of moving accounts, contracts, court judgments, mortgages, security agreements, and evidence of perfection of lien. DO NOT SEND ORIGINAL DOCUMENTS. If the documents are not available, explain. If the documents are voluminous, attach a summary. <b>9. DATE-STAMPED COPY:</b> To receive an acknowledgment of the filing of your claim, enclose a stamped, self-addressed envelope and copy of this proof of claim.					
The original of this completed proof of claim form must be sent by mail or hand delivered (FAXES NOT ACCEPTED) so that it is actually received on or before 5:00 pm, prevailing Pacific time, on November 13, 2006 for each person or entity (including individuals, partnerships, corporations, joint ventures, trusts and governmental units). BY MAIL TO: BMC Group c/o USACM Claims Docking Center Box 911 Escondido, CA 92045-0911 BY HAND OR OVERNIGHT DELIVERY TO: BMC Group Attn: USACM Claims Docking Center 1330 East Franklin Avenue El Segundo, CA 90245					<b>THIS SPACE FOR COURT USE ONLY</b>
DATE: <b>11/8/06</b>		SIGN and print the name and title of 2% of the creditor or other person authorized to file this claim (attach copy whenever appropriate, if any): 			

Penalty for preparing fraudulent claim is a fine of up to \$500,000 or imprisonment for up to 5 years, or both. 18 U.S.C. §§ 152 AND 3571.

EXHIBIT SC

<b>1065</b> Form 1065 Department of the Treasury Internal Revenue Service		<b>U.S. Return of Partnership Income</b> For calendar year 2009, or tax year beginning _____, ending _____ <b>EXTENSION GRANTED TO 09/15/10</b>		OMB No. 1545-0099 <b>2009</b>	
<b>A</b> Principal business activity <b>REAL ESTATE DEVELOPERS</b>	Use the IRS label. Otherwise, print or type.	<b>Name of partnership</b> <b>BINFORD MEDICAL DEVELOPERS, LLC</b>		<b>D</b> Employer identification number <b>87-0707497</b>	
<b>B</b> Principal product or service <b>REAL ESTATE</b>		Number, street, and room or suite no. If a P.O. box, see the instructions. <b>5200 E. 64TH STREET</b>		<b>E</b> Date business started <b>01/24/2007</b>	
<b>C</b> Business code number <b>531390</b>		City or town, state, and ZIP code <b>INDIANAPOLIS IN 46220</b>		<b>F</b> Total assets <b>\$ 10081367.</b>	
<b>G</b> Check applicable boxes: (1) <input type="checkbox"/> Initial return (2) <input type="checkbox"/> Final return (3) <input type="checkbox"/> Name change (4) <input type="checkbox"/> Address change (5) <input type="checkbox"/> Amended return (6) <input type="checkbox"/> Technical termination - also check (1) or (2)					
<b>H</b> Check accounting method: (1) <input checked="" type="checkbox"/> Cash (2) <input type="checkbox"/> Accrual (3) <input type="checkbox"/> Other (specify) <span style="border-bottom: 1px solid black; display: inline-block; width: 100px;"></span>					
<b>I</b> Number of Schedules K-1. Attach one for each person who was a partner at any time during the tax year <span style="border-bottom: 1px solid black; display: inline-block; width: 100px; text-align: center;">2</span>					
<b>J</b> Check if Schedules C and M-3 are attached <span style="float: right;"><input checked="" type="checkbox"/></span>					

**Caution.** Include only trade or business income and expenses on lines 1a through 22 below. See the instructions for more information.

<b>Income</b>	1 a Gross receipts or sales	1a	49,026.		49,026.
	b Less returns and allowances	1b			
	2 Cost of goods sold (Schedule A, line 8)	2			
	3 Gross profit. Subtract line 2 from line 1c	3			49,026.
	4 Ordinary income (loss) from other partnerships, estates, and trusts (attach statement)	4			
	5 Net farm profit (loss) (attach Schedule F (Form 1040))	5			
	6 Net gain (loss) from Form 4797, Part II, line 17 (attach Form 4797)	6			
	7 Other income (loss) (attach statement) SEE STATEMENT 1	7			-49,026.
8 Total income (loss). Combine lines 3 through 7	8				
<b>Deductions (see the instructions for limitations)</b>	9 Salaries and wages (other than to partners) (less employment credits)	9			
	10 Guaranteed payments to partners	10			
	11 Repairs and maintenance	11			12,627.
	12 Bad debts	12			
	13 Rent	13			
	14 Taxes and licenses	14			
	15 Interest	15			11,203.
	16 a Depreciation (if required, attach Form 4562)	16a	9,041.		
	b Less depreciation reported on Schedule A and elsewhere on return	16b			9,041.
	17 Depletion (Do not deduct oil and gas depletion.)	17			
	18 Retirement plans, etc.	18			
	19 Employee benefit programs	19			
	20 Other deductions (attach statement) SEE STATEMENT 2	20			4,816.
	21 Total deductions. Add the amounts shown in the far right column for lines 9 through 20	21			37,687.
22 Ordinary business income (loss). Subtract line 21 from line 8	22			-37,687.	

<b>Sign Here</b>	Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than general partner or limited liability company member manager) is based on all information of which preparer has any knowledge.		May the IRS discuss this return with the preparer shown below (see instr.)? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	Signature of general partner or limited liability company member manager <span style="float: right;">Date</span>			
<b>Paid Preparer's Use Only</b>	Preparer's signature	Date <b>04/20/10</b>	Check if self-employed <input type="checkbox"/>	Preparer's SSN or PTIN <b>313-46-6637</b>
	Firm's name (or yours if self-employed), address, and ZIP code <b>FORD &amp; COMPANY, INC.</b> <b>12800 N MERIDIAN ST, SUITE 325</b> <b>CARMEL, IN 46032</b>		EIN <b>35-2108852</b>	Phone no. <b>(317) 816-1100</b>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Form 1065 (2009)

## Binford Medical Developers, LLC



Action ▾

### Similar Companies Nearby (Industry participants & competitors)

Name	Empl.	Dist. (mil)
J S Ruiz Realty Inc.	5	0.2
Hawthorn Properties LLP	2	0.2
Sheila R Noel Agt	2	0.2
Our House Real Estate	1	0.9
C A Klemme Real Estate Services	99	1.0
Wilsano Properties Indy, LLC	2	1.1
Metro Indianapolis Brd. of Real	2	1.2
Remax On Lake	2	1.2
Past & Present	2	1.4
44 Clear Lake LLC	2	1.8

### Contact Information

**Binford Medical Developers, LLC**  
5200 E 64th St  
Indianapolis, IN 46220

Contact: Kenneth E Schmidt  
Title: Member  
Phone: (317) 979-1700  
Website:

There are 5 Companies located at 5200 E 64th St, Indianapolis, IN 46220

Map

### Business Description

Binford Medical Developers is located in Indianapolis, Indiana. This organization primarily operates in the Real Estate Agents and Managers business / industry within the Real Estate sector. This organization has been operating for approximately 15 years. Binford Medical Developers is estimated to generate \$271,130 in annual revenues, and employs approximately 3 people at this single location.

Sector: Real Estate  
Category: Real Estate Agents and Managers  
Industry: Real Estate Agents and Managers  
SIC Code: 6531

Name: Binford Medical Developers, LLC  
Year Founded: 2003  
Engaged In:  
☐ Manufacturing  
☐ Importing  
☐ Exporting

State of Inc: Indiana  
Location Type: Single  
Revenue: \$ 271,130  
Employees Here: 3  
Facility Size: N/A  
\* Revenue & Employees are estimates

### Statistics for Zipcode 46220

Average House Value \$188,100  
Average Household Income \$61,907  
Number of Households 16,431  
Persons per Household 2.11

### Demographics for Zipcode 46220

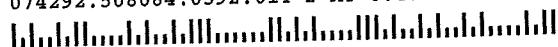


IRS Department of the Treasury  
Internal Revenue Service  
CINCINNATI, OH 45999-0039



7105 5678 7187 7668 3794

074292.508084.0592.014 2 AT 0.471 1554



BINFORD MEDICAL PARTNERS II LLC  
SCHMIDT KENNETH E SINGLE MEMBER  
5200 E 64TH ST  
INDIANAPOLIS IN 46220-4708007



074292

EXHIBIT 5B

0.1% Hawaiian

1.5% Other

Population  
34,830

Median Age  
35.4



**ASSET RECOVERY TRUST**

2973 HARBOR BLVD. #200  
COSTA MESA, CA 92626

714-546-8100  
800-923-0880  
FAX 714-435-1792

Member Better Business Bureau  
800-600-7050 www.la.bbb.org

Email: [amelone@asset-recovery.net](mailto:amelone@asset-recovery.net)

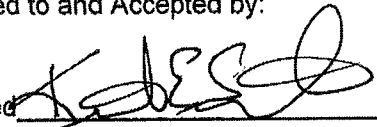
**SERVICES AGREEMENT**  
**(Limited To One Transaction Only)**

ASSET RECOVERY TRUST will provide to **BINFORD MEDICAL DEVELOPERS, LLC** and or its **successors in interest**, hereinafter referred to as "Client," with the completed legal forms necessary to recover unclaimed funds of **\$12,746.52**, ready for Client's signature.

IN consideration of this recovery for Client, it is agreed that Client hereby assigns to ASSET RECOVERY TRUST a service fee of ~~10%~~ of the actual funds recovered, with this assignment solely contingent upon receipt of these funds. 15% 12/03

IT is further agreed that all costs and expenses involved in this recovery process shall remain with and be the responsibility of ASSET RECOVERY TRUST.

Agreed to and Accepted by:

Signed  Name KENNETH E. SCHMITT  
(Please Print)

Company BINFORD MEDICAL DEVELOPERS, LLC Title MANAGING PARTNER  
(Please Print exact legal name)

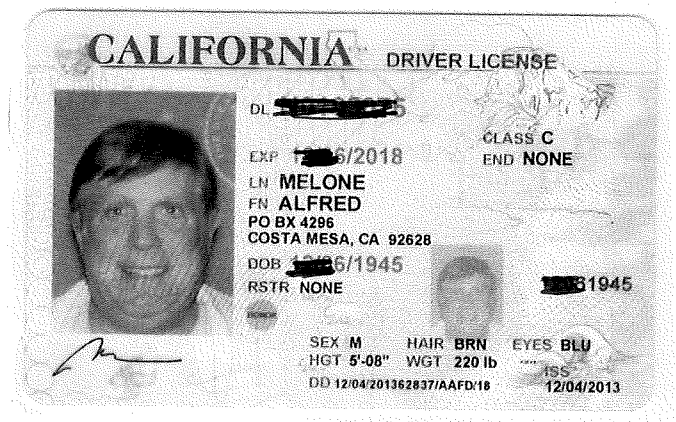
Address 3250 N. POST RD SUITE 150 Phone 317-979-1700

Date 10-4-18

Email K.SCHMITT@SCHMITT ASSOCIATES.NET  
(Optional)

VL443

EXHIBIT 2



AO 213  
(Rev. 02/15)ADMINISTRATIVE OFFICE OF THE UNITED STATES COURTS  
Accounting Division**VENDOR INFORMATION/TIN CERTIFICATION**  
Mandatory Information that MUST be provided before submission

☐ Ex-AO Employee  
☐ SAM Vendor  
 (Formerly CCR)  
 (No TIN Certification Required)

Vendor Address Select all that apply <input checked="" type="checkbox"/> Order <input type="checkbox"/> Remit <input type="checkbox"/> 1099	Other Address (If different from Vendor Address) Select all that apply <input type="checkbox"/> Order <input checked="" type="checkbox"/> Remit <input type="checkbox"/> 1099
Name: BINFORD MEDICAL DEVELOPERS, LLC	Address: C/O ASSET RECOVERY TRUST, P.O. Box 4296
Business Name: (if different from above)	City: Costa Mesa
Address 1: 3250 N. Post Rd. #160	State: CA Zip Code: 92628
Address 2:	Phone #: 714-546-8100
City: Indianapolis	Description: (If needed)
State: IN Zip Code: 46226	
Phone #: 317-979-1700 E-mail:	
Taxpayer Identification #: 87-0707497 (TIN, SS, or EIN number)	
DUNS #	
Financial Information (If Requested)	
Bank Name:	Routing # (this nine digit number appears on your checks, but do not include individual check numbers):
City:	Account #:
State: Zip Code:	Type of Account: (select one) <input type="checkbox"/> Checking <input type="checkbox"/> Savings

Type of Organization for 1099 reporting:

- ☐ sole proprietorship; ☐ partnership;  
☒ corporate entity (not tax-exempt); ☐ corporate entity (tax-exempt);  
☐ health care provider; ☐ other: \_\_\_\_\_  
☐ government entity (write in either federal, state or local)

**Taxpayer Identification Number Certification**

Under penalties of perjury, I certify that:

- The Taxpayer Identification Number listed in the Vendor Address area above is the correct number assigned to me, and
- I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest and dividends, or (c) the IRS has notified me that I am no longer subject to the backup withholding, and
- I am a U.S. citizen or other U.S. person (defined below).

☐ You must select this check box if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. If you make a false statement with no reasonable basis that results in no backup withholdings, you are subject to a \$500 penalty. Willfully falsifying certifications or affirmations on this form may subject you to criminal penalties including fines and/or imprisonment.

AO 213  
(Rev. 02/15)

**Definitions:**

"Taxpayer Identification (TIN, SS, or EIN number)" is the number required by the Internal Revenue Service (IRS) to be used in reporting income tax and other returns. The TIN may be either a social security number (SSN) or an employer identification number (EIN).

"U.S. person" means:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States.

The TIN, as well as the information above is required in order to comply with debt collection requirements of 31 U.S.C. §§ 7701(c) and 3325(d), reporting requirements of 26 U.S.C. §§ 6041 and 6041A, and implementing regulations issued by the IRS. Failure or refusal to furnish this information may result in 28 percent backup withholding on any payments otherwise due under any awarded contract or purchase order.

The TIN may be used by the government to collect and report on any delinquent amounts arising out of the vendor's relationship with the government (31 U.S.C. § 7701(c)(3)). The TIN provided may be matched with IRS records to verify its accuracy.

Complete this section only if a TIN was not provided on page one, and select closest reason why not:

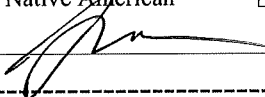
- ☐ The vendor is a nonresident alien, foreign corporation or foreign partnership that does not have income effectively connected with the conduct of a trade or business in the United States and does not have an office or place of business or a fiscal paying agent in the United States;
- ☐ The vendor is an agency or instrumentality of a foreign government;

**Additional information required for vendors used for procurement  
(purchase orders, contracts, etc.)**

Indicate which, if any, of the following categories are applicable. These categories require that the vendor is 51% owned and the management and daily operations are controlled by one or more members of the selected socio-economic group:

- ☐ Women Owned Business ☒ Not Applicable
- ☐ Minority Owned Business (If yes, select one of the owner's race/ethnicity selections from below):
- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Asian-Pacific American | <input type="checkbox"/> Black American  | <input type="checkbox"/> Subcontinent Asian (Asian-Indian) American |
| <input type="checkbox"/> Hispanic American      | <input type="checkbox"/> Native American | <input type="checkbox"/> Other: _____                               |

Date: 1-4-19

  
Vendor's signature

**For Agency Use Only**

The vendor name and DUNS number is all that is required for registered System for Award Management (SAM) vendors (formerly CCR). (Check [www.sam.gov](http://www.sam.gov) for registration status.) Do not use this form for purchase card merchants.

Mark Boxes that apply: ☐ Addition ☐ Change ☐ Vendor Code: \_\_\_\_\_ (make entry only if change)  
☐ Active ☐ Inactive ☐ Vendor Type: \_\_\_\_\_

The following information is optional for individuals whose name and telephone are already on the form:

Contact Name: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_ Email: \_\_\_\_\_

**Identification of person making this request:**

Name: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_ Originating Office: \_\_\_\_\_

Please type or print clearly.

Please type or print clearly. For JIFMS Users only, e-mail the completed form to: [jifms@support.aotx.uscourts.gov](mailto:jifms@support.aotx.uscourts.gov). For Court FAS4T Users, send this form to the local court Vendor Administrator. For questions regarding JIFMS and Court FAS4T please contact SDSO at (210) 301-6320.

This form should be completed with signature by the vendor and submitted by Judiciary staff only.  
Sensitive information must be securely maintained and only visible to the appropriately designated financial employee.